

**MARICOPA INTEGRATED HEALTH SYSTEM HEALTH PLANS
PROTOCOL**

SUBJECT: CPAP, Nasal	Protocol #: PA P139.02 Protocol Pages: 2 Attachments: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Initial Effective Date: June 1999 Latest Review Date: May 2002
APPLIES TO: MHP <input checked="" type="checkbox"/> MLTCP <input checked="" type="checkbox"/> MSSP <input checked="" type="checkbox"/> HEALTHSELECT <input checked="" type="checkbox"/>	
MIHS HEALTH PLANS APPROVALS: Director, Medical Management _____ Date: _____ Medical Director: _____ Date: _____	

PURPOSE: The purpose of this protocol is to state the Prior Authorization Criteria that the Medical Management Department will use as it pertains to CPAP, Nasal.

PROTOCOL:

- A. The prior-authorization specialist may approve if reviewed **by a prior authorization nurse** and **all** of the following are present:
 - 1. Polysomnography (sleep study) reveals **at least one** of the following:
 - a) An apnea index (AI) of at least 20 per hour, regardless of symptoms;
 - b) An apnea-hypopnea index (AHI) of at least 30 per hour, regardless of symptoms;
 - c) An apnea index (AI) of at least 10 per hour **WITH** excessive daytime sleepiness;
 - d) A respiratory arousal index (also called “respiratory disturbance index”) of at least 10 per hour **WITH** excessive daytime sleepiness.
 - 2. The CPAP prescription is written by a health plan approved pulmonologist.
 - 3. Member does not use narcotics or sedating medications;
- B. The following require Medical Director approval:
 - 1. Autotitrating CPAP machines and
 - 2. Bipap.
- C. This criteria is a guideline for prior authorization and does not represent a standard of practice or care.
- D. This protocol addresses medical coverage issues only and does not review individual benefit coverage issues. In order to issue an authorization number, the procedure must meet medical guidelines and benefit coverage guidelines under the specific plan.
- E. If requirements are not met, Medical Director review is required.

ATTACHMENT:

A. Sleep Study Questionnaire

2 Pages

Total Attachment Pages 2

MIHS Health Plans reserves the right to change the protocol for administrative or medical reasons without notification to external entities. This protocol is not intended to be utilized as a basis for a claim submission.

Patient _____

Date _____

Height _____ Weight _____

CC: _____

Sleep Apnea Symptoms

Snoring? YES ☐ NO ☐ UNKNOWN ☐
Witnessed apneas? YES ☐ NO ☐ UNKNOWN ☐
Patient report? YES ☐ NO ☐ Family confirmation? YES ☐ NO ☐
Hypersomnolence? YES ☐ NO ☐ UNKNOWN ☐
Epworth Sleepiness Scale Score _____
While driving or falling asleep at a traffic light? YES ☐ NO ☐
Other significant impairment secondary to sleepiness? _____

Associated Respiratory Conditions

COPD/Asthma YES ☐ NO ☐ Degree of control? _____
Other: YES ☐ NO ☐ Degree of control? _____
Does patient use nocturnal oxygen? YES ☐ NO ☐ Flow rate? _____
PFTs Date _____ FEV _____ FVC _____ Not done _____

Other Sleep-Related Symptoms

Restless legs or periodic limb movements of sleep? YES ☐ NO ☐
Insomnia? Early ☐ Middle ☐ Late ☐ Non-restorative sleep ☐
Sleepwalking or other sleep behaviors?
Describe _____
Other? _____

Other Medical Conditions

Thyroid Disease? YES ☐ NO ☐ Degree of control? _____

Medication List

Potential impact on sleep symptoms? YES ☐ NO ☐
Adjustments needed prior to sleep study? YES ☐ NO ☐

Comments

Signature

Signature

**SLEEP QUESTIONNAIRE
(Epworth Sleepiness Scale)****Patient's Name** _____ **Date** _____**How likely is it that you will fall asleep in the following situations? Please circle a number for each situation.****0 = would never doze****1 = slight chance of dozing****2 = moderate chance of dozing****3 = high chance of dozing**

Sitting and reading	0	1	2	3
Watching t.v.	0	1	2	3
Sitting in a public place, like a waiting room	0	1	2	3
Riding in a car for one (1) hour	0	1	2	3
Lying down to rest	0	1	2	3
Sitting & talking	0	1	2	3
Sitting after lunch without alcohol	0	1	2	3
In a car while stopped in traffic	0	1	2	3

Total Score _____